



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to [www.GuideStone.org/PlanBooklets](http://www.GuideStone.org/PlanBooklets). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.HealthCare.gov/sbc-glossary/> or call 1-844-467-4843 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-network: \$5,000 person / \$10,000 family. Out-of-network: \$10,000 person / \$20,000 family.	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , primary care services, generic drugs, diabetic supplies and insulin are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.HealthCare.gov/coverage/preventive-care-benefits/">https://www.HealthCare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$7,900 individual / \$15,800 family; for <a href="#">out-of-network providers</a> : no limit.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, specialty drug <a href="#">copayments</a> paid by the manufacturer, <a href="#">premiums</a> , health care this <a href="#">plan</a> doesn't cover, and out-of-network <a href="#">balance-billing</a> charges.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.guidestonehealth.org">www.guidestonehealth.org</a> or call 1-855-497-1230 for a list of participating providers.	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$0 Primary Care or Retail <a href="#">copayment</a>	50% <a href="#">coinsurance</a>	\$0 Primary Care or Retail <a href="#">copay</a> . \$70 Specialist (for visits 1-3) <a href="#">copay</a> . Primary care includes retail clinics. <a href="#">Deductible</a> does not apply to the <a href="#">copays</a> .
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge for covered services	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (X-ray, blood work)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	If performed in a primary care or specialist office, primary care or specialist <a href="#">copay</a> applies. <a href="#">Deductible</a> does not apply to the <a href="#">copays</a> .
	Imaging (CT/PET scans, MRI's)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Prior authorization (PA) required for non-emergency advanced imaging procedures (e.g., MRI, CT, PET) performed in an outpatient setting.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.GuideStone.org">www.GuideStone.org</a>	Generic drugs	\$15 <a href="#">copay</a> /prescription retail \$30 <a href="#">copay</a> /prescription mail (Deductible does not apply.)	100% of drug cost. Upon manual claim form submission, you will be reimbursed based on plan benefits and allowable charges for covered drugs.	Covers up to 30-day supply retail and 90-day supply mail order. The difference in cost of brand drugs over available generic drugs is a non-covered penalty. The above penalties do not accumulate toward the <a href="#">deductible</a> or <a href="#">out-of-pocket limits</a> . Certain contraceptives are not covered.
	Preferred brand drugs	\$50 <a href="#">copay</a> /prescription retail \$125 <a href="#">copay</a> /prescription mail		
	Non-preferred brand drugs	\$75 <a href="#">copay</a> /prescription retail \$185 <a href="#">copay</a> /prescription mail		
	Diabetic Supplies (Generic, Preferred, Non-preferred)	\$20 <a href="#">copay</a> /prescription mail ( <a href="#">Deductible</a> does not apply.)		Covers up to a 90-day supply. <a href="#">Deductible</a> does not apply.
	Participating Insulin	\$75 <a href="#">copay</a> /prescription mail ( <a href="#">Deductible</a> does not apply.)		Covers up to a 90-day supply. <a href="#">Deductible</a> does not apply. Insulin copay applies to select insulin products whose manufacturers have chosen to participate in the Patient Assurance Program.
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a>		Covers up to a 30-day supply. <a href="#">Copayments</a> for certain <a href="#">specialty drugs</a> will be set to the maximum available manufacturer <a href="#">copay</a> assistance and be paid by the manufacturer.

[\* For more Information about limitations and exceptions, see the plan or policy document at [www.GuideStone.org/PlanBooklets](http://www.GuideStone.org/PlanBooklets).]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a> after \$300 <a href="#">copay</a>	30% <a href="#">coinsurance</a> after \$300 <a href="#">copay</a>	-----None-----
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Air ambulance always pays at in network level. Other transportation, if an emergency, pays at the in-network level and waives <a href="#">deductible</a> .
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$120 Urgent Care (for visits 1-3) <a href="#">copay</a> . <a href="#">Deductible</a> does not apply to the <a href="#">copays</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after 30% <a href="#">copay</a>	-----None-----
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Primary <a href="#">copay</a> is \$0 Primary Care or Retail. Specialist \$70 Specialist (for visits 1-3) <a href="#">copay</a> for visits 1–3. Primary care includes retail clinics. <a href="#">Deductible</a> does not apply to the <a href="#">copays</a> .
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after 30% <a href="#">copay</a>	Precertification may be required.
If you are pregnant	Office visits	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	\$0 Primary Care or Retail <a href="#">copay</a> . \$70 Specialist (for visits 1-3) <a href="#">copay</a> . Primary care includes retail clinics. <a href="#">Deductible</a> does not apply to the <a href="#">copays</a> .
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> after 30% <a href="#">copay</a>	-----None-----
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maximum 120 visits per year.
	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	See plan booklet. Limits may apply.
	<a href="#">Habilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	See plan booklet. Limits may apply.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Maximum 30 days per year.
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Rental or purchase option determined by the claims administrator. Rental costs cannot exceed the total cost of purchase.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	-----None-----

[\* For more Information about limitations and exceptions, see the plan or policy document at [www.GuideStone.org/PlanBooklets](http://www.GuideStone.org/PlanBooklets).]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	See <i>Preventive Care Schedule</i> for age limits on child vision screening.
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	See <i>Preventive Care Schedule</i> for exceptions.

[\* For more Information about limitations and exceptions, see the plan or policy document at [www.GuideStone.org/PlanBooklets](http://www.GuideStone.org/PlanBooklets).]

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)

- Abortion
- Acupuncture
- Certain contraceptives
- Cosmetic surgery
- Chiropractic care
- Dental care (Adult)
- Experimental or investigational treatment
- Infertility treatment
- Long-term care
- Private-duty nursing
- Private hospital room
- Routine eye care (Adult)
- Routine foot care
- Weight loss program

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan document](#).)

- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Hearing aids

**Your Rights to Continue Coverage:** Church plans are not covered by the federal COBRA continuation coverage rules. Other options to continue coverage are available to you, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: MyQHealth Care Coordinators at 1-855-497-1230 or visit [www.guidestonehealth.org](http://www.guidestonehealth.org).

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**For seminary students:** This plan is Minimum Essential Coverage only if you are (1) an ordained, commissioned or licensed minister or (2) a paid employee of a Southern Baptist employer, or approved evangelical ministry, working 20 or more hours/week.

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al **1-844-INS-GUIDE** (1-844-467-4843).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-844-INS-GUIDE** (1-844-467-4843).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-844-INS-GUIDE** (1-844-467-4843).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-844-INS-GUIDE** (1-844-467-4843).

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$70 (for visits 1-3)
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Specialist](#) Office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$70
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$7,370</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$70 (for visits 1-3)
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Primary care physician](#) Office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$1,400
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,500</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$70 (for visits 1-3)
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic tests](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.